A COMPREHENSIVE HEALTHCARE PLAN
FOR
ALL COLORADO RESIDENTS

COMPREHENSIVE

a(1) What problems does this proposal address?

1. The financial burdens individual faces when they are sick or injured.
2. The inefficient and costly allocation of healthcare capital in Colorado.
3. Healthcare benefits and income replacement for every employee and family, 24 hours per day, 7 days a week.
4. A long term plan to reduce the cost of healthcare services.
5. The financial problems of Federal and State entitlement programs.

a (2) What are the objective of this proposal?

1. Implement major reform of the current health, disability and life insurance plans so that all Colorado residents and their families are insured 24 hours a day, 7 days a week.
2. Eliminate the State mandated and inefficient workers compensation system and the medical payment provision of automobile insurance policies.
3. Equitably fund quality health care services to all Colorado residents and seasonal workers.
4. Outline a Plan that will address suitability, portability, sustainability and cost containment,

GENERAL

b(1) Describe your proposal in detail.

When an individual becomes sick or is injured, the following questions arise:

a. Will professional services and facilities be available too assist in the recovery?
b. How will they pay for the services?
b. If their paycheck stops, what financial resources will they use to live on?
c. Will they lose their home and assets if they can't return to gainful employment?
d. If they don't survive, what financial resources will their family live on?

Numerous health care professional and citizens question the quality of the medical system in Colorado. Our opinion is that the system is undoubtedly one of the finest in the world. Rural areas may suffer from a lack of facilities and doctors, but the population of those areas does not justify building multi-million dollar facilities. With modern transportation it is cost effective to transport patients to strategically located medical centers. Therefore this proposal will not address the issue of quality.

The inability to pay for health care services and sustain a satisfactory lifestyle due to an injury or sickness is one of the major causes of financial crisis. In a research study conducted by Harvard law and medical school, over 47% of the Colorado bankruptcies filed in 2001 were due to illnesses that caused loss of income and medical bills. (1) Colorado is one of the leading states for mortgages foreclosures; many time the direct result of an inefficient insurance plan. Sickness and injury can be directly linked to consumers being forced to make drastic financial decisions and the loss of dignity. This chain of events usually results in the debtor applying for assistance from the federal and state entitlement programs. The process for qualifying for disability through the Social Security Administration can take years, if the claim is not totally rejected. If successful, the entitlement is usually less than fifty percent of pre-disability income. These financial burdens lead to family conflicts, drug and alcohol abuse, crime and loss of human capital. The burden on the Medicare, Medicaid and Social Security programs is destroying the financial integrity of those programs. These financial catastrophes are indicative of the widespread problems directly related to the inefficient allocation of healthcare capital in Colorado.

Most of the private research and U.S. government studies fail to address one of main causes of the financial crisis in U.S. and Colorado healthcare system. Why has no one addressed the problem business face annually when they are forced to allocated substantial capital to purchase an inefficient and archaic accident insurance policy called “workers compensation insurance”? Our assertion is that reform of the healthcare funding system is impossible without including the cost and limited benefits of workers compensation system.

After thirty years of financial planning for business, we found a majority of employers and employees are uneducated about the benefits paid by workers compensation insurance. Employees assume that if a sickness or injury occurs at work, the incident will trigger insurance payments for all the services. Transparency is not an important policy for worker compensation insurance companies

An analysis of the time of the day when an injury or sickness take place will dictate which insurance policy will pay for the medical services. Automobile owners purchase insurance with medical payment riders to cover the cost of injuries sustained in an accident. Approximately 60% of Colorado citizens purchase health insurance policies to cover injuries and sickness. Since the 1920's, employers have been required by state law to purchase "workers compensation" insurance to cover the medical cost resulting from an injury to an employee. Allocating healthcare capital to three or more insurance policies is inefficient, confusing and results in substantial additional cost to the consumer, medical providers and insurance companies.

Automobile insurance regulations promulgated by the Colorado legislature in 2003 decreased the requirements for providing medical services in a policy. Many automobile owners reduced or eliminated the medical payment rider if they also owned an individual health insurance policy or were covered by an employer sponsored group health plan. The change in law resulted in health insurance companies assuming additional exposure to automobile injury claims. Health insurance companies increased premiums by an average of five percent (5%). Over the past four years, those health insurance companies have been able to contain cost within the premium increases.

Workers Compensation Insurance reduces the liability an employers could incur should an employee sustains an injury or occupational sickness during their 8-10 hours of employment. The policy cover medical services if the insurance company accepts the claim. Based on the latest statistics from the Department of Labor and Employment for 2003, worker compensation companies denied 24% of all the claims filed. (2) If the injury results in loss of time, the employee is compensated for 66% of his pre-injury gross income. If the injury results in an employee's death, beneficiaries are compensated through a settlement. Approximately 75% of fatal claims resulting from heart attacks that occurred during work were denied. (2) In 2005 workers compensation carriers paid medical, disability and life insurance claims totally 68% of the $982 million of premium collected from employers. (3) The gross profit margin of 32% is an incentive for more than one hundred fifty companies to sell the product in Colorado. From 1994 through 2003, Colorado's work force has grown by 22% while workers compensation claims have dropped by 21%. This is a testimony to the fact that employers are accountable for worksite safety.

Workers compensation insurance served its purpose when it was the only benefit to employees. But in the past twenty years, the government mandated for this type of insurance has become a financial burden for companies, their employees and the health care system. The substantial profits earned by the workers compensation insurance industry has contributed to the health care funding crisis that our country now faces. Compounding the health care crisis is the fact that a disabled employee would most likely be denied individual health insurance because he has a pre-existing condition. If he was denied income replacement benefits, his only option may be to qualify for the government entitlement programs. If given the option, most employers would not purchase a policy that covers only accidents, eight hours per day, like workers compensation. Yet our government continues to mandates ineffective plans. In group meetings we asked employees what insurance company underwrites their workers compensation insurance, what benefits the policy provided, which doctors do they consult with and do they carry a benefit card to present to the medical service provider. Very few employees could correctly answer any of the questions. Workers compensation is not transparent. It is a very inefficient use of healthcare capital to provide accident benefit eight hours a day, five days a week.

Health Insurance policies are the primary source of coverage for medical services that consumers purchase or are provided through group plans sponsored by employers. But the rising cost of health insurance premiums (54% over the past five years) has caused employers to re-evaluate their responsibility to provide employee benefits and remain competitive in their industry. The Colorado legislature continues to mandate that medical insurance policies cover services that are customarily referred to as alternative medicine. These mandates increase cost and have forced many insurance companies to withdraw from the state, reducing competition and consumer choice. In addition, health insurance companies restrict benefits during the eight hours people are employed since medical services are suppose to be paid by the workers compensation insurance. The consumer, health insurance company and medical service provider are trust into a confusing predicament and costly administrative nightmare in trying to determine which policy is liable for a claim.

Disability Insurance is the most important insurance a person can purchase. This statement is based on the fact that an individual without income is a tremendous burden on a free market economy. Income replacement is a difficult concept for people to comprehend. Everyone assumes that health insurance is the most important policy a consumer should purchase. Representatives from the government, the media, politicians and health care providers continue to expound on that theory. We have questioned numerous consumers about this issue. "If they had the option, who should be covered when they are

injured or sick?" Would it be the "the medical provider or them"? After a long pause, invariably the answer is they want to be paid. Disability insurance provides for the financial needs of the insured. During the time of a disability, the policy pays the home mortgage, utilities, car payment, food, clothing, rehabilitation, education, medical services and insurance. It is the one insurance plan that provides people with the opportunity to endure an injury or sickness and maintain a quality of life.

The workers compensation plan provides income replacement to disabled employees. The problem occurs when a sickness manifest itself during employment and is not covered. Statistics show that one percent of the claims filed for occupational sickness are paid by workers compensation insurance companies. (3) If an injury occurs while the employee is at work and results in a long-term disability, a lump-sum settlement is the worst possible solution for the employee. Most disabled employees cannot prudently manage a lump sums settlement. The money is usually spent irresponsibly, until the funds are exhausted. When faced with the realty of an empty bank account, disabled former employees are forced into foreclosures on their mortgage, bankruptcy and humiliation. Ultimately the disabled employee will apply for government entitlement programs. The only winners in most of the workers compensation cases are the attorneys who receive 30 to 40% of the settlement. The U.S. economy cannot afford the numerous insurance policies that responsible consumer are forced to purchase to cover their possible sickness and injury liabilities.

b(2) Who will benefit from this plan?

Our Plan would require legislation that mandates all employers in Colorado purchase private health, disability and life insurance to cover employees 24 hours per day, 7 days a week. Workers compensation would be eliminated and replaced with the new system. Approximately 95% of the residents and their families would be provided quality health insurance through their employer. Self-employed people would be guaranteed the same medical, disability and life benefits. The cost of the plan would be shared equally by the employer and employee through payroll deduction and administered by the employer. The employer would be held harmless from lawsuits filed by employees, similar to current law. But employers would be held liable for negligence. Dependents, spouses and families would have medical insurance coverage 24 hours a day, 7 days a week. The Plan would be administered by a government sponsored Board of Directors appointed by the legislature and governor. Every resident in Colorado would benefit from this Plan. We think this Plan will stimulate the economic growth through the relocation of new business to the State. Reducing the cost of

employee benefits, plus increasing the coverage to 24 hours a day, 7 days a week should be an important motivation for companies. Building the industrial base in Colorado will improve tax revenues and may lower the state income tax rate and property tax levy. Businesses have to be competitive to remain viable to attract stockholders and capital. Our Plan provides universal benefits to all residents.

The Disability Plan would provide a tax-free benefit of 70% of the pre-disability income earned by a disabled employee. The plan would cover the employee 24 hours per day, 7 days a week for sickness and accidents. The benefits would be underwritten and administered by private insurance companies. The Colorado Division of Insurance would issue a license to insurance companies who maintained substantial reserves to sustain the plan. Disabled residents would be required to be under the care of a physician to receive a benefit. Rehabilitation services would be included in the plan and mandatory for all claimants. Based on recent employment statistics, the plan would cover 95% of the residents working in Colorado. The seasonal work force would not qualify for disability benefits. Spouses and children would not be insured. The Board would define who was a resident. Lump sum payments for disability would not be allowed. Monthly benefits would continue until a disabled person reached age 67 or returns to work. A sub-committee of the Board would rule on disability claims that were contested by the insurance company or employee. The cost of the plan would be paid equally by the employer and employee thorough payroll deductions. All premiums would be tax deductible at the State level. The state legislature would request an amendment of the current federal code to eliminate taxation of disability benefits. Premium increases would be monitored and ruled upon by the Division of Insurance and the Board.

Under our Plan disabled former employees would continue to be insured for health insurance through their last employer. Since the disabled employee would be receiving a tax-free income, the insurance company underwriting the disability claim would deduct the monthly premiums for health insurance and send the funds to the employer.

The Life Insurance Plan is intended to provide a benefit of 70% of the deceased employees monthly earnings. The insurance company underwriting the plan would pay a monthly annuity to the spouse for life. No lump sum payments would be available to a beneficiary. And the beneficiary could not sell the annuity for a lump sum to a third party. If the insured were not married at the time of death, the benefits would be paid to the guardian of minor children, established by the district courts. Unmarried

employees could designate anyone as their beneficiary. Seasonal workers would not be insured. The benefits would be income tax and estate tax free. The life insurance would be guaranteed issue, with no pre-existing limitations. Approximately $200,000 of life insurance on each employee would be required to fund the monthly installment. The employer and employee through payroll deductions would pay the cost of the life insurance benefit. The life insurance would be underwritten by licensed life insurance companies and sold by agents.

The Medical Plan would be guaranteed issue to all employees and their families without any pre-existing condition reducing benefits. The insurance companies underwriting the medical benefits would have the option of offering a cafeteria menu of optional benefits to the employee. An example would be maternity coverage for employees age 20 through 50 years of age. Mental health benefits, substance abuse, smoking cessation and alternative medicine options would be included in the cafeteria plan. The employee would select the optional benefits that would meet their family's need and pay an additional fee for those services. This plan would empower employees to become involved in health care decisions for their family and accountable for managing the cost.

The medical plan would include two options. The first would be a PPO plan with a $1,000 calendar year deductible per person, with a maximum of two deductibles per family. The second option would be indemnity plans where the insured pays 20% of the first $5000 of service and the insurance company pays 80%. The company pays 100% of the balance up to $1 million. Both plans would cover all primary and preventive care, specialist, surgical and hospital services, laboratory and x-rays, emergency care and transportation, prescription drugs, medical equipment, patient education, physical therapy and rehabilitation services and hospice care. When a sick or injured person has utilized $1,000,000 of medical services, the Colorado Medicaid program would take responsibility for the cost of future services. Since the Plan would cover ever resident, immigrant and disabled person, the current financial burden on Medicare and Medicaid system would be reduced substantially. A tax-deductible health saving account (H.S.A.) would be an option incorporated into the plan to pay for the deductible and provide a savings plan that would help stimulate the economy.

Every employee and family member would have an identification card that describes their benefits and the insurance company underwriting the plan. The plan would be portable as employees change jobs. The employee and dependents would immediately enroll in their new employers plan. The

administration of the documents would be the responsibility of the employer when a new employee is hired.

b(2) Who will be negatively affected by this proposal?

Workers compensation insurance would be terminated by legislation. Insurance companies writing workers compensation and agents selling the insurance would be negatively affected. Those companies that have developed a complete system for monitoring and paying claims for workforce injury and sickness could convert their company to a full-service health insurance company. Our analysis of the Department of Labor and Employment statistics leads us to believe that many of the workers compensation companies are so poorly capitalized that they would not venture into the new Plan to underwrite health, disability or life insurance.

The attorneys representing claimants will mount a serious campaign to discredit this plan. Based on Colorado Insurance Commission statistics, attorneys would lose over $75 million dollars annually for legal fees. They would be negatively impacted. But under the current system, the cost of workers compensation reflects the fees earned by attorneys involved in workers compensation settlements. Attorneys would be negatively impacted by this Plan. But the residents would have lower insurance premiums since the legal cost would be eliminated.

b(3) How will your proposal impact specific group of people?

Seasonal employers (agriculture) would be required to fund a mini-medical plan for the migrant workers and their families, plus uninsured resident farm labor, with insurance provided by a non-profit, state chartered organization similar to Pinnacle. The Plan would include $100,000 of reimburse medical services. All the services of a fully insured plan would be covered, but at a reduced total reimbursement. The monthly cost of the benefits would be the same for everyone working on a farm and divided equally between the employer and employee through payroll deductions. This plan would force agriculture employers to pay minimum wages and discontinue using cash as an incentive to underpay farm labor. Employers would be required to follow the current state laws regarding documentation of workers, checking immigration status, compensating workers fairly and paying taxes as per the law. Due to the temporary, transient nature of the seasonal employment, agriculture workers would be given an identification card issued by a state agency and the card would be valid until they

stop working or exited the state. Each employer would utilize the account number of the seasonal worker to fund the plan. All employers would be required to log into the statewide information system maintained by the non-profit company to document the seasonal employee and their family. Hopefully this plan would start the process of monitoring the illegal immigrants and give the seasonal worker and family an incentive to utilize the health care system, abide by federal and state laws and work towards U.S. citizenship. All documents would be written in English and Spanish. Migrant workers usually work for a number of farmers during the growing season. Therefore the collection of insurance premiums would be documented by the farmer and paid into the non-profit company. Federal W-2's would be compared to the premiums collected and billed to the farmer if the premiums were under-paid. Many farms retain labor year around, therefore this plan would fund medical services to the employee and their family.

The uninsured and unemployed resident and their family would have the opportunity to purchase guaranteed issue health insurance through the non-profit company for a substantial reduction in cost, similar to the seasonal employee. State tax revenues would offset a portion of the total cost. The non-profit company administering the plan should operate at a lower cost than the private health insurance companies, justifying the premium discount. Medical service providers would be paid a lower fee for service to assist with the discount. The non-profit Pinnacle Assurance Company would have the opportunity to change course and become the primary insurance company to administer the Plan for the seasonal worker, rural employee, disabled and uninsured. The plan would be advertised in the newspapers and other media throughout the state. Agents licensed by the Insurance Commissioner would be responsible for educating and selling the plan to the public.

b(4) Please provide evidence regarding the success of your approach.

Over the past four years we have monitored the cost of workers compensation insurance and a fully insured PPO health insurance to the thirty- six employees of an underground utility construction company with headquartered in Windsor, Colorado. The Employer paid the total cost of the PPO plan that insured every employee and their family. The company experience minimal claims on the workers compensation. The group was very healthy and utilization of the PPO was substantially below the claims/loss ratio projected by the insurance company. Total payroll for 2006 was $1,863,000, with the three owners opting out of the workers compensation plan. After discussing the issues with the owners, we proceeded to develop a plan underwritten through United Health Care (UHC) and Met Life

(Met) insurance companies. Under Colorado law the employer could not implement the plan due to workers compensation, therefore it is only hypothetical. The PPO plan, disability and life insurance would provide benefits 24 hour a day coverage, 7 days a week. For 2006 the Plan would have provided savings of 24%, which calculates to be of over $100,000. This Plan will insure the employees 24 hours a day, 7 days a week. (4)

b(5) How will the program be governed and administered?

The Board would establish the cost of each service and health care procedure based on the Federal standards set by Medicare. When Medicare was established it implemented a limited reimbursements and controlled cost system for all procedures. Physicians and hospital complain about the reimbursement, but it is one of the only equitable systems that have controlled medical cost. The Board would develop a system to monitor cost and revenues. Each year the Board would have the option of increasing medical service reimbursement from the initial level by using an Index established by an average of the Consumer Price Index and a factor to be determined. Insurance companies would no longer be allowed to increase premiums unilaterally. The Board and the Insurance Commissioner would be charged with setting premium rate increase tied to the Index. The Board would be compensated for their services as full time employees of the State and serve a term not dictated by political parties.

All fees for medical services would be advertised in the physician's office, hospital and any other medical service provider's location. The transparency of the system would be efficient and allow patients to become responsible consumers. The competition to control administrative cost and overhead would force insurance companies and the medical service providers to become more accountable. The medical community would no longer negotiate fees for service. Physician networks would be eliminated. Each diagnosis and procedure would be paid a set fee. Medical providers would know their entitlements and have to live within the reimbursement. Under the Plan, the hospitals and physicians would be reimbursed for approximately 95% of their services. Under the current system health care providers are paid less than 75% of billings. No longer would service providers be forced to write-off or cost shift millions of dollars of health care cost. Throughout the health care system gross revenues would increase. Rural communities could afford to up-graded or build new facilities and contract with physicians and other service providers. Insurance companies would benefit from the proposal. They would know their cost and administration of claims would be efficient and objective.

An integrated, statewide health information system network would be established to track utilization and expenses of all citizens in the plan. Insurance companies would no longer dictate the care of the sick and injured. The insurance companies, hospitals and medical providers would utilize standardized forms that would reduce administration and overhead. This system would free hospitals, physicians and health care professionals to perform their services in an open forum, without regulation by insurance companies.

b (6) Would federal or state laws need to be modified?

The cost of the insurance premiums would be tax deductible to employers and employees, whether they filed form IRS form 1040 or the short form. Federal and state laws would have to be change. Currently the Adjusted Gross Income regulations limit deduction of health insurance premiums to excess above the 7.5% of AIG. The H.S.A. contribution would be totally deductible. The Federal regulation regarding the maximum life insurance that an employer could provide on a group plan would have to be modified. Workers compensation laws would be eliminated. In their place would be regulations regarding employer liability and workplace safety. Most of the current laws could be modified to regulate employers and employees. Automobile insurance regulations would require modification to eliminate the medical payments requirements.

b(7) How will the program be implemented?

Assuming the proposal was accepted and developed further than this documents is capable, the Plan would:

1. Suggest a beta testing period in which a few employers in all of the SIC industrial classes would be allowed to insure their employees under the new plan. The objective would be to measure the efficiency and performance of the plan. This would take approximately two years to accumulate reliable data.
2. During the two years testing period, development of a Medicare type reimbursement system could be studies and established.
3. Insurance companies would have the two years period to develop cost analysis, design the software to manage the claims and policy specifications.
4. The Board would be appointed to start the process of administering the plan.

5. The non-profit company (Pinnacle) would be charged with developing systems and actuarially computations to fund the Mini-Medical program. The mini-medical plan would be implemented during the two-year period and tested on farms throughout the state.

ACCESS

c(1) Does this proposal expand access?

After the testing period, the Plan would be communicated to the public, employers, employees, uninsured and migrant workers through the media, both in English and Spanish. The health, disability and life insurance plans would be transparent. Since the delivery system would be through insurance agents, they would be required to attend training session conducted by companies and the insurance commissioners office. Standardized forms would be used to simplify the registration. The medical providers and hospital would have to revamp their systems and educate staff on the claims process. Since all services would be advertised, the providers would need time to develop their communication system and documents to show exhibit the fee for all their services.

As the public became educated on the new system, interest would expand. Specially trained interpreters and agents would communicate the plan to the migrant workforce since they will be suspicious of the intent to monitor their immigration status. Access to health care services is a choice. You cannot force people to comply if they have a motive for not being involved.

c(2) How will the program affect safety net providers?

Probably the most competent and best source for communicating this Plan to the uninsured and migrant workforce is through the safety net organizations. They are trusted and will be the front line professionals to implement the plan. They will also learn that the reimbursements for their services will be over 95%, so revenues to the non-profit should be increasing when the plan is implemented.

COVERAGE

d(1) Does the proposal expand coverage?

Yes, based on the Plan, every resident in Colorado will have access to the benefits and be covered. Health care coverage is available to residents and uninsured if they want to take advantage of the Plan. The cost for the mini-medical plan will dictated by usage. Migrant workers would be forced to pay for the benefits, therefore they should have expanded coverage if they are not intimidated by the immigration issues. Tax revenue in the general budget will possibly have to be allocated to fund the min-medical plan. The benefits of the Plan are superior to the current plan, with 24 hours a day coverage, every day of the year. Disability benefits will be one of the most important features.

d(2) How will outreach and enrollment be conducted?

Outreach will be a function of the health care providers, hospitals and safety net providers learning the new system and communicating affectively to the residents. The identification cards will be an important element for the public to understand the transparency of the system. The licensed agents will be on the front line educating business owners and employees on the health, disability and life benefits, plus they will educate the employer on administration procedures. The effort to educate the public will be one of the primary responsibilities of the Board members from each region that will be communicating the plan to everyone involved. Enrollment will take place in-group meetings at the employer's offices, with uninsured in their home with the agents and in many venues. The most important part is the standardized forms and communication of the cost so people know their financial accountability and empowerment. The statewide information network will be a vital part of the total system.

d(3) Define residents?

The resident issue will be defined by the State legislature as per the constitution. Enforced will be controlled by the Board.

AFFORDABILITY

e(1) What will be the premium-sharing requirement?

As noted in the Plan, employers and employees will share equally in the cost of the benefits. The uninsured and unemployed migrants will pay a discounted rate for the min-medical plan. Employees of seasonal employers will share the cost equally. The cost of the insurance will be substantially reduced due to the Medicare based reimbursement plan, standardized forms for communicating claims and single, integrated technology system.

e(2) How will co-payments and cost-sharing be structured?

The Plan empowers people to save money for medical expenses through the Health Savings Account (H.S.A.). Utilizing the H.S.A. funds to pay for deductible and co-pays empowers families to monitor and be accountable for services. If a major objective of the Commission is to recommend a plan that reduces the cost of health insurance, requiring the insured to pay for the first $1,000 or incorporate a 20% coinsurance in an indemnity plan will accomplish that objective. Co-pays in a medical insurance Plan that insures everyone in the state is not cost shifting but rather cost-sharing with the underwriting company. Couple that concept with the Plan to limit medical reimbursement based on a Medicare cost containment system and the outlay of funds on co-payments for physician services and drugs should be limited. The H.S.A. is an important tool in the overall Plan to build equity for the family. As noted in a number of studies, most people experience the majority of their medical service cost in the last quarter of their life. Building a savings account that will be funding medical expenses in the later period of the insured's life will ease the burden on the entitlement system

PORTABILITY

f(1) Describe any provision for assuring that individuals maintain access to coverage even in life changing circumstances?

The Plan we are prescribing is portable. If an employee changes careers, employment or is un-employed they will maintain their coverage. The first situation is that they move to another employer, where they will be covered the first day of the next month following employment for health, disability

and life insurance. They have already paid for the month they leave the employer so they are covered for the balance of the month. If they change careers and become self-employed, they have to purchase the guaranteed issue plan that is identical to the plan they came from while employed. The cost for the benefits will increase since they will not be sharing their skills and the premiums with an employer. The self-employed can take the option to enroll in the mini-medical plan if premiums are an issue and still retain the disability and life insurance benefits at there cost. If the resident is unemployed then the disability part of the Plan is not available, but the life and medical plans will be continued.

Transferring to a public program would be similar to transferring to a new employer. The public program would have medical, life and disability plan that are the same as the private sector. Public employees would not need workers compensation since they have the all the necessary benefits, 24 hours a day, 7 days a week. All of the plan would comply with federal Cobra and state continuation laws regarding portability.

BENEFITS

g(1) Describe how and why you believe the benefits under your proposal are adequate, have appropriate limitations and address distinct populations?

The Plan calls for a fully insured medical, disability and life insurance coverage. It covers all the medical services available in any city in Colorado, to every resident and their family. In addition, the disability Plan covers all employees with a benefit of 70% of their pre-disability income for sickness and injuries. This benefit covers more than twice the hours for sickness and injury than the current worker compensation plan provides, for less money. The limitations on the medical plan of $1 million of total services is adequate, especially since the cost above that threshold will be transferred to the Medicaid program. In discussions with health insurance companies, very few claims exceed the million-dollar limit. Dental and vision coverage would be an optional benefit that an employer could provide to the employees. But during the first five years the basic plan of medical, disability and life insurance would have to run the course to determine whether optional benefits would be prudent and cost effective.

A number of areas of the state are dealing with health issues that can be mitigated with education on nutritional and diet, exercise and the change in behavior of the residents. An example is the rapid

development of diabetes in the population of the southwest, south central rural areas of the State. We propose that one of the main functions of the safety net providers is to deal with these issues. Another segment of the population that must be addressed in the Plan is the mentally ill, residents suffering from substance abuse and homeless. The min-medical plan is designed to accommodate the aforementioned segments of the population. The benefit for mental health portion of that policy would be similar to the full-insured PPO plan, with limitations on total amount of service. Unlike an injury or sickness that usually has a start and end, the mental health issue is open ended and difficult to quantify. It is beyond the scope of this writer to address this issue without statistics and actuarial data to support a position.

g(2) Identify an existing Colorado benefit package that is similar to the one you are proposing?

Currently there are many PPO plans in the Colorado market sold through private insurance companies. These plans provide excellent benefits to the employees but are over-priced and inefficient to administer both for the insurance company and medical providers. One of the obvious problems is the voluminous diagnostic and procedural coding systems. Currently the plan has numerous co-pays and deductibles, overwhelming medical staff, patients and insurance company claims representatives. The explanation of benefits (EOB) statements provided by the insurance company is difficult for the medical provider staff to interpret and the patients are totally confused. When the medical providers final statement arrives at the patient's home, the misunderstanding is magnified. The biggest complaint in the medical field is the administration cost and the time wasted by staff trying to interpret the systems. The Plan we are proposing would simplify the administrative procedure so that approximately 30% of the cost of the insurance premium will be eliminated. Standardized medical forms will start the process. Patients will be made aware of the cost before they leave the medical facility. The insurance company claims department will not be subjectively interpreting the statement from the doctor, since the coding will be universal. The reimbursement system, which is similar to Medicare, and established by the Board, will be universal to all physicians and hospitals. The insurance company will process the provider's statements, send the reimbursement through the Federal Reserve System and the medical provider will book the payment to the patient account with minimal disruption and administrative problems. Medical provider will spend less time and revenue on administration and more time on patient care. Revenue will flow smoothly reducing the time in which funds are available for provider to pay for overhead and expenses of the operations. The accounting staff at the medical providers and insurance will be reduced due to the streamlined system, saving

millions of dollars in administrative cost. The plan should pay over 95 % of the medical services invoices based on the insurance reimbursement system we have designed. Medical facilities will see revenue increase and this should stimulate advances in research and care. We anticipate the healthcare industry will improve its economic position in the next five years. Driving down health insurance premiums and leading the world in the quality of health care for all residents and immigrants is the goal.

The insurance industry is the largest buyers of bonds that are sold by municipalities, government, private and public companies and medical facilities. We think it is prudent for the Commission to promote a pubic-private partnership between the insurance industry and the medical providers. The flow of funds between successful healthcare providers and the private insurance companies can be a force to fuel the countries entrepreneurial economy.

QUALITY

h(1) How will quality be defined, measured and improved?

The definition for "quality" will be defined by the Board. Currently there are many excellent medical facilities and healthcare professionals in Colorado who would be classified as quality. Over the next 10 to 20 years the issue will arise and intelligent leaders will rise to the challenge. The measurement of a plans success will come from utilization, cost and access studies. An entrepreneurial society does not accept the norm, but continues to strive for improvements in all of the systems. The progress in developing solutions that will fight disease by the major universities, pharmaceutical companies and research companies is testimony to mans quest for excellence.

h(2) How, if at all, will quality of care be improved?

The great strides that medicine has taken in the past one hundred years cannot be discounted. The public will invest substantial tax revenue and private capital to create systems to extend life. Our Plan will include a statewide healthcare information system that will be confidential to meet the HIPPA regulations, yet accessible to the professionals. With data collection and integration the Board will have a unique opportunity to monitor results and establish policies that will govern the healthcare

system. Healthcare providers will be awarded for outstanding performance as the public evaluates results and increase utilization of their services.

EFFICIENCY

i(1) Does your proposal decrease or contain health care cost and how?

The Plan will provide immediate savings through a number of avenues:

1. Providing health, disability and life insurance to over 95% of the population will reduce the number of foreclosures, bankruptcies and human suffering that is directly attributed to inability to sustain income during a prolonged illness or injury. The savings to the public is immeasurable.

2. Controlling the cost of healthcare services through one defined reimbursement system, based on the Medicare model, will bring immediate savings of (10 to 15%) to the residents, hospitals, physicians and insurance companies. Providers will be paid the same whether they practice in rural or the metropolitan areas.
3. Developing a standardize form for physicians to use throughout the State for reporting diagnosis and procedures will save approximately 10% of the current system-wide cost, including administrative fees for the provider, insurance company and patient.

4. As residents are empowered by the new Plan, they will reduce their demand on the Federal and State entitlement programs. Providing income replacement insurance to 95% of the non-seasonal employment base will create a dynamic reduction in cost to the public systems and provide a resource for assuring dignity to those who are disabled.

5. As savings are generated throughout the healthcare system with the decrease in over-all cost, new technology and treatment will be funded and provide the residents with countless savings.

6. A dramatic reduction in the substance abuse and mental health related problems that society currently endures will be measurable as residents utilize the new Plan.

7. As the new Plan is implemented, preventive care will be affordable and utilized by more residents. Defensive medicine will be reduced and the 20% of the population that consumes 80% of the current healthcare dollar will be reduced

8. It is impossible to measure the savings to the population when residents have funds to support their families with dignity. Child and spousal abuse will decline, criminal intent due to drug and substance abuse should decrease and the family structure should improve.

9. The Board will establish a single, statewide prescription drug formulary. With this system in place the cost of medicine should be driven down substantially, especially with bulk purchasing for all pharmacies to utilize.

10. The single information technology system will reduce cost and save healthcare providers time in their quest to treat emergency situations and reduce the demand on immediate care facilities.

The positive economic impact on the residents of Colorado that the new Plan will create is the real measure of its success.

i(2) To what extent does your proposal use incentives for the providers, consumers, plans or others to reward behavior that minimizes cost and maximizes assess and quality in the healthcare services?

Initially, providers will be discouraged by the reduced reimbursement that will be implemented immediately by the Board as it develops and refines the Medicare based fee for service. But as the healthcare professional income increases due to over 95% reimbursement, they will recognize the value of practicing in Colorado. The successful system should bring new physicians to the state and energize the field.

The incentive for consumers will be better health, financial outlook and a renewed entrepreneurial spirit that will fuel the states economy. Educating the public on the value of progressive medicine, utilizing preventive care and emphasizing positive behavior will be the most rewarding outcome for the new Plan.

Insurance companies will embrace the cost control features of the Medicare based fee for service. The Plan will decrease administrative cost to operate the insurance company, and revenues and profits will improve. Those companies that have left the state due to state mandates will witness the increased profits and join their peer in providing the insurance to fund the Plan

i(3) Does this proposal address transparency of cost and quality?

Yes, the new Plan will completely change the way healthcare is communicated to the residents. Healthcare providers will be forced to identify the cost for each procedure and communicate that expense to the consumer. Unlike the current system, the new Plan will be totally transparent in all phases of the process. Residents will be educated on the plans, how to utilize services and what the cost will be and how the Plan will benefit them financially.

i(4) How would your proposal impact administrative cost?

The benefits of the plan will be established by the Board and standardized for consumers, healthcare providers and insurance companies underwriting the Plan. The administrative cost to all of the principals will be reduced substantially. A single integrated system will provide stability and affordability to the all parties. Competition between the insurance companies to reduce premiums to capture markets will drive administrative cost down. The Medicare based reimbursement system will streamline the processing of filing claims and funding services. We anticipate a reduction in administrative cost of 10 to 20% of the current system.

CONSUMER CHOICE AND EMPOWERMENT

j(1) Does your proposal address consumer choice?

Yes, the consumer will be able to select the healthcare professional and facility without interference from the insurance company underwriting the Plan. Empowering the consumer to save money in a tax deductible health saving account will stimulate accountability for healthcare services. The old system required paying for services without transparency. That issue will no longer be a concern of the consumers. Before they leave the healthcare facilities, consumers will know the cost of the service and

be accountable for understanding the system. Insurance companies and healthcare providers will no longer be able to hide the true cost of the services or the reimbursement. Open access to the integrated technology system with a user name and password will give residents the power to monitor reimbursements and claims. With their identification card consumers can choose the facility and provider in any area of the state.

j(2) How, if at all, would your proposal help consumers to be more informed about and better equipped to engage in health care decisions?

Under our Plan, the consumer would have the ultimate choice to select the healthcare provider that meets their needs. With the assistance of the media, well-educated agents and the healthcare professionals, the Plan will be highly publicized so that consumers can elect to be well informed about the benefits and cost of the services. No longer will the consumer be led through the system without being informed and educated on the advantage of the benefits. Education starts at a young age, therefore the Plan would be mandated by the legislature to be included in the public and private school education curriculum. The process will stimulate the younger generations to make informed decisions about nutrition, dieting, abuse and overall healthcare.

WELLNESS AND PREVENTION

k(1) How does your proposal address wellness and prevention?

The foundation of the Plan will be prevention and wellness in tandem with unlimited access to services, education and information. The family physician will become the primary care provider and source for unlimited information. Their compensation will directly reflect the important role they provide in the overall system. Patient education is the responsibility of both the educator and the student, no matter what age. The Board will establish public classes taught by healthcare providers, safety net providers and insurance agents to bring accountability to the forefront of the system. Patient education, prevention and alternative services will be the milestones for wellness.

SUSTAINABILITY

l(1) How is your proposal sustainable over the long term?

The cost saving addressed in the Plan are extensive. As the consumer becomes more educated on the benefits and services of the Plan, the long term affects will be measurable in terms of the reduction in cost per resident, healthier populations, quality healthcare and economy growth. Consumer-directed healthcare is the ultimate goal of the plan. The Board will be the catalyst for monitoring the progress of the Plan and educating the residents as the results are quantified. No longer will foreign insurance companies and government entities dictate the healthcare of the population. This Plan is initially sustainable by investing the $20 billion dollars currently allocation as healthcare capital by businesses, taxpayers and private entities. As the cost savings of the Plan are earned over the first five years, the economic impact will be utilized to lower cost, increase benefits and continue the process.

l(2) How much do you estimate the proposal will cost? How much do you estimate the proposal will save?

After the two-year beta testing period, the projected cost of the Plan will be defined. We have estimated the first year cost will be approximately $12 to $20 billion dollars, based on the 2005 allocation of healthcare capital as noted in the Insurance Commissions report. Since the Kaiser plan would have to be integrated into the system, their budget skews the total cost. The cost for companies who currently self-insure is another factor that must be factored into the equation. The start-up cost of this venture is unpredictable until the independent consulting firm can conduct their analysis.

The savings inherent in our Plans assumptions will be generated in the administrative cost and the Medicare based reimbursement system. Plan and benefit utilization will be monitored throughout the first two years to allow the Board to decide on the cost per resident. Some factors cannot be quantified in this proposal, only estimates at this stage of the process.

l(3) Who will pay for any new cost under your proposal?

This proposal cannot address additional cost for our Plan since there are so many unknown factors in the structure of the benefits. Terminating workers compensation will shift that capital to the new Plan along with expenses associated with new disability benefits insuring employees 24 hours a day, 7 days a week. Over the longer period of time the impact on the Federal and State entitlement programs by shifting the benefits and expense to our Plan employees and not relying on the social programs will be substantial savings to taxpayers.

I(4) How will distribution of costs for individuals, employers, employees, government, or others affected by this proposal? Will each experience increase or decrease costs?

Since every employers and self-employed business owner will be mandated to provide health, disability and life insurance to employees the distribution of healthcare capital will shift to the new Plan. The discontinued workers compensation plan will shift premiums into the equation as will the cost of providing the expanded benefits. Employee's current insured and those without benefits will experience an increase in their cost of the benefits as they share in the premiums with their employer. But the employee will no longer pay for the medical payment rider on their automobile policy, so that will be a savings. The seasonal farm labor will have an extensive benefit package, with new cost to cover the Plan. There are no free rides in this Plan. Every resident and family will have benefits and coverage and everyone will pay.

I(5) Are there new mandates that put specific requirements on payers in your proposal? Are any existing mandates on payers eliminated under your proposal?

The new Plan would mandate that every employee, seasonal worker, uninsured, immigrant and their families would be responsible for enrolling in the plan. The Plan is universal and equitable in coverage and cost. The workers compensation mandate would be terminated by the Legislature. Any mandates for automobile owners, commercial fleet owners and other intrastate transportation equipment to have a medical payments rider on their policy, unless specifically required, would be eliminated. Legal staff would have to review the mandates to determine the extent of the regulations.

l(6) How will your proposal impact cost-shifting?

Cost shifting in our Plan will be eliminated as everyone is covered and benefits are paid by a standardized system of reimbursements. Annually the Board will establish the reimbursement fees based on the CPI and other indexes.

l(7) Are new public funds required for your proposal?

The current allocation of health care capital as noted in the 2005 Insurance Commission report, updated to the current year will fund the Plan. We do not anticipate the requirement for additional funding from public sector. The final analysis by the independent consultant will expand on that statement. Historically, taxing the public sector for new programs created unnecessary administrative cost, overhead and was inefficient. The U.S. is noted in the world for it low tax rate and entrepreneurial spirit. Our Plan reduces the financial impact on the Federal and State entitlement programs. Privatizing systems historically has cost less than a socialistic program of government trying to take care of every citizen and equalize wealth.

COMPREHENSIVE

This Plan is comprehensive. Our Plan provides universal healthcare, income replacement (disability) and life insurance for every employee in the state. The healthcare services covers every family, seasonal employees, immigrants, uninsured and unemployed and their family, 24 hours a day, 7 days a week. The Plan benefits are extensive and are funded through private insurance companies. We emphasize the importance of including the insurance industry in this Plan. Insurance companies will manage this plan more efficiently than any government entity. The structure of the reimbursement fees will limit the increase in premiums that insurance have been forced to shift to the consumer. Health care professionals and facilities will adjust to operating within the fee schedule and with 95% of the patients being covered the providers will see a substantial increase in revenue. Challenging the inefficient and costly workers compensation insurance plan will raise a lot of concern from attorneys and insurance companies. But those entities are not concerned about the health and welfare of the residents of Colorado. The terms of the Plan are equitable for everyone associated with the proposal.

END NOTES

1. Rocky Mountain New, source; Harvard University Law and Medical School, Feb. 2, 2005

2. Colorado Department of Labor and Employment, Division of workers compensation, "Work-related Injuries in 2003"

3. Colorado Insurance Commission,"2005 Colorado Insurance Industry Statistical Report" page 263

4. Benefit-Cost Comparison for Utility Contractor